Steps for MR Waiver Case Managers: Assisting Individuals to Participate in Money Follows the Person (MFP)

*For the most part, the following processes/forms are **in addition to** the usual MRW required processes/forms. Use this document in conjunction with the MR Waiver "When to Submit What" guide.*

	Case Manager Actions	Materials/Forms Required
1.	Review the information you have about individuals currently residing in the following types of facilities: • nursing homes ① • training centers/small provider ICFs/MR② • long-stay hospitals ③ to determine who might like to receive services in the community. To qualify for MFP the individual must • have resided in one of the above settings for at least six consecutive months; • be a resident of the Commonwealth of Virginia; • be Medicaid eligible for at least one month at the time of discharge; and • move to a "qualified residence" (see #3 below).	
2.	Meet with the individual/family members/legal guardian/AR to explain the opportunity posed by the MFP slots (110 available for MR Waiver in FY09 and 110 available in FY10) and ascertain interest. Share marketing information: tri-fold, summary info and Project Guidebook (all available from DMAS).	- MFP brochure - "Moving to the Community from an ICF/MR Under the Money Follows the Person Demonstration Project" (MFP Summary Information) - "Project Guidebook"
3.	For those who express interest, assist them in reviewing choices of available "qualified residences" in their desired community. A qualified residence is: 1) a home that the individual or a family member owns or leases; 2) an apartment with an individual lease, with lockable access and egress, that includes living, sleeping, bathing and cooking areas over which the individual or the individual's family has domain and control; or	

	3) a residence in a community-based residential setting in which no more than four (4) unrelated individuals reside. **NOTE**: If an individual does not choose one of the above qualified residences, he/she may still move from the facility, but will not be eligible to participate in MFP. Contact your Office of IDS representative.	
4.	Case managers (CMs) may bill one month of Targeted Case Management for pre-discharge activities occurring during the 30 days immediately preceding discharge. See the MR Community Services Manual, Chapter IV, p 9 (2nd paragraph under "Service Units and Service Limitations") for more information.	
5.	Review with the individual/family members/legal guardian the **DMAS MFP Informed Consent** form. Complete the signature page and retain this form in the individual's record for QMR.	"Informed Consent for Participation in Virginia's Money Follows the Person Rebalancing Demonstration" (DMAS 221)
6.	Complete the **MFP Enrollment form** and fax to Vivian Stevenson (804-786-8626).	"Request for Enrollment in Money Follows the Person" (DMAS 222)
7.	Complete the following usual forms to enroll the individual in the MR Waiver and fax to Vivian Stevenson (804-786-8626): • Enrollment Request form • Slot change/Allocation form (check FY09 Facility Slot **and** MFP) • Recipient Choice form. Complete all other MR Waiver required forms according to schedule (e.g., DMAS-122, Provider Choice form, etc.).	- Enrollment Request form (DMAS 437) - Slot Change/New Assignment Fax Cover form (DMHMRSAS 885E 1202) - Recipient Choice form (DMAS 459-C)
8.	Complete the **Essential Information** form to meet OL requirements for medical information and individual history. (available online at www.dmhmrsas.virginia.gov). Individual completes **Individual Profile** with person of choice for sharing at person-centered plan meeting	-Essential Information - Partner list -Individual Profile

	(available online at www.dmhmrsas.virginia.gov). Complete **PCP Partner List** to identify preferred participants in person-centered plan meeting (available online at www.dmhmrsas.virginia.gov).	

9.	If the individual is moving into any of the qualified residences EXCEPT a group home (i.e., a private residence in which the individual is directly responsible for his/her own living expenses), he/she may access **Transition Services (TS)**. Transition Services (funding) are a maximum of $5,000 per-person/lifetime for household set-up expenses reimbursement. TS are limited to a total of 9 months from date of authorization. See pp. 76 – 78 of the MFP Project Guidebook for more information. Since these are available up to 2 months prior to discharge (for MFP participants only), ISARs requesting TS may be sent to the Preauthorization Consultant PRIOR TO the individual exiting the facility, if there will be pre-discharge qualifying expenses (ISAR available at www.dmhmrsas.virginia.gov). All single requests for items over $2,000.00 will require DMAS review. TS operate like Environmental Modifications or Assistive Technology in that the CSB "up-fronts" the money for the allowable expenses and then requests reimbursement. One difference is that reimbursement is provided through Public Partnerships, LLC (PPL). CSBs must complete a provider enrollment package with PPL, which may be obtained by contacting them at 866-529-7550.	Transition Services ISAR (DMAS 417)

11.	Prior to discharge the case manager must complete the **MFP Quality of Life Survey** (found in Appendix 2 of the MFP Program Guidebook) with the individual. The completed Quality of Life Survey is sent to: Jason Rachel DMAS 600 East Broad Street Suite 1300 Richmond, VA 23219	

12.	The case manager, chosen community providers, individual, family/guardian/AR, and others desired by the individual should meet prior to facility discharge to engage in a Person-Centered Planning process. The following **person-centered planning forms** should be used for service planning purposes: • Individual Profile (completed before meeting – see step #8) • Individual Support Plan • Discussion records • Planning questions • Agreement page All of the above forms are available online at www.dmhmrsas.virginia.gov). In addition, each individual participating in MFP must have a standard **Risk Assessment** completed (which is Section 4 of the Virginia SIS). The Risk Assessment should assist the team in determining essential services (defined as those services that are necessary to eliminate undue risk to the individual's health and safety). The team must include back-up plans for essential services within the service plan. The back-up plan must identify specific arrangements that have been made to maintain the individual's health and safety in the event of a breakdown in each of these essential services. Contact your IDS Community Resource Consultant with questions about these forms or processes.	- Individual Profile - Individual Support Plan - Discussion records -Planning questions -Agreement page Risk Assessment form
13.	Prior to discharge, ISARs for services to be delivered on an ongoing basis should be faxed to the CSB's Preauthorization Consultant.	Various ISARs
14.	If an individual is re-admitted to a facility listed in step #1 and stays there for more than 30 days, he/she will be disenrolled from MFP and the MR Waiver. However, if the stay in the facility is expected to be time-limited, the slot may be held and the individual may re-enroll into MFP without having to meet the requirement for six (6) consecutive months of institutional residency. The case manager must complete the Retain Slot form after 60 days and every 30 days thereafter.	"Retain or Reassign Slot of Individual Not Currently Receiving Waiver Services" form

① Includes Children's Hospital of Richmond's long-term care section and the Renaissance Pediatric Unit of Iliff Nursing and Rehabilitation Center in Dunn Loring among others.
② Ensure the small provider ICFs/MR are certified, and the individual is in a certified bed.
③ Includes Lake Taylor Hospital in Norfolk and Hospital for Sick Children in Washington, D.C.

IMPORTANT THINGS TO KNOW

- It is essential that the case manager working with someone exiting a facility via MFP familiarize herself with the content of the *MFP Project Guidebook* and *Appendix C of the MR Community Services Manual* (available at www.olmsteadva.com/mfp/).

- Environmental Modifications is available *prior to facility discharge* only for those participating in MFP.

- Other non-Waiver benefits available to MFP participants are "**supplemental home modifications**" (equipment or modifications of a remedial or medical benefit to the individual's primary home to specifically improve his/her personal functioning, which must be completed in order for him/her to safely move into the home) and "**bridge rent**." Up to $45,000/person is available for supplemental home modifications. Bridge rent is available to cover rental payments from the time the individual signs a lease until he/she can move into a residence that is undergoing environmental modifications or supplemental home modifications. Both are available through the Department of Housing and Community Development for individuals whose household income is at or below 80% of the area median income. More information about these two benefits is available in the Project Guidebook on pp. 74 – 76.

- Transition Services funding is available to **any** individual receiving MR Waiver who is moving into a qualifying residence (see #9 above) – not just MFP participants. However, only MFP participants may access these funds prior to leaving a facility. [Example: an individual plans to move from a group home into his own supervised apartment with a roommate. Because he will be paying towards his own living expenses (even though he is sharing those with a roommate), he is eligible for Transition Services funding to help pay security deposits, purchase household essentials, etc.].

- If a CSB plans to provide Transition Coordination services to individuals exiting facilities for the EDCD Waiver (this service is the case management equivalent for the EDCD Waiver ONLY) it is necessary to first enroll with First Health to provide this service.